Iowa Department of Administrative Services – Human Resources Enterprise

APPLICATION FOR SUPPLEMENTAL TERM LIFE INSURANCE

Employee Statement

Employee Name: _____

Social Security Number: _____

Birth Date: _____ Age: _____

I have forwarded an "Evidence of Insurability" form to The Hartford Insurance Company according to the plan's *Evidence of Insurability* requirement. I understand that my application will be approved or denied regardless of the amount of insurance for which I am applying.

I wish to apply for **supplemental** life insurance coverage in the following amount:

SPOC Employees Only:

- ☐ $5,000
- ☐ $10,000
- ☐ $15,000
- ☐ $20,000
- ☐ $25,000
- ☐ $30,000

UE/IUP Employees Only:

- ☐ $5,000
- ☐ $10,000
- ☐ $15,000
- ☐ $20,000
- ☐ $25,000
- ☐ $30,000
- ☐ $35,000
- ☐ $40,000

All Other Full Time Employees:

- ☐ $5,000
- ☐ $10,000
- ☐ $15,000
- ☐ $20,000
- ☐ $25,000
- ☐ $30,000
- ☐ $35,000
- ☐ $40,000
- ☐ $45,000
- ☐ $50,000
- ☐ $55,000
- ☐ $60,000
- ☐ $65,000
- ☐ $70,000
- ☐ $75,000
- ☐ $80,000
- ☐ $85,000
- ☐ $90,000
- ☐ $95,000
- ☐ $100,000

REASON FOR CHANGE

The request to increase my supplemental term life insurance is due to the following event:

☐ **Annual Enrollment and Change Period**

Change in Your Legal Marital Status

- ☐ Marriage
- ☐ Divorce
- ☐ Legal separation
- ☐ Annulment
- ☐ Death of spouse

Change in the Number of Your Dependents

- ☐ Adoption or placement for adoption
- ☐ Birth
- ☐ Death of dependent
- ☐ Dependent is no longer eligible because of age, student status or marital status

Change in your Spouse's Employment Status

- ☐ Spouse terminates employment

Date of Event
(Required if the change is due to a qualifying life event.)

_____

I am enrolling for coverage and I authorize the State of Iowa to deduct from my earnings supplemental life insurance premiums under a contract issued by The Hartford Insurance Company. I declare the statement above is true and understand it is the basis for determining my eligibility and the monthly contribution for coverage.

Employee Signature: _____ **Date:** _____

Employee: After signing and dating, give this form to your Personnel Assistant.

Please refer to the Booklet Certificate for all plan details, including any exclusions, limitations and restrictions which may apply.

Employer Statement

Personnel Assistant Name: _____

Employee's Current Life Code: _____

When completed, send the form to:

Iowa Department of Administrative Services
Human Resources Enterprise
Group Life Insurance
Hoover State Office Building
Des Moines, IA 50319-0150

DAS-HRE Use Only

Effective Date: _____

Change Code from _____ to _____

Hartford Decision

- ☐ Approved
- ☐ Declined
- ☐ Closed

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